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No. 05-1350

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SUPREME COURT, U.S.

In the Supreme Court of the United States

NEVA MURRAY, INDIVIDUALLY AND AS GUARDIAN OF HUGH MURRAY, WARD,
Petitioner,

v.

CROSSMARK SALES, INC.; CONNECTICUT GENERAL LIFE INSURANCE CO.; and GROUP & PENSION ADMINISTRATORS, INC.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Should this Court reconsider the well-settled standard of review of a plan administrator's decision to deny benefits under Section 502(a)(1)(B) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), as set out in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), where the Petitioner raised no challenge to the standard of review in the District Court or Court of Appeals, and the ERISA plan exclusion at issue unambiguously precludes recovery?

2. Should this Court review the treatment by the lower courts in this case of the doctrine of reasonable expectations in the context of an ERISA plan where there is no circuit split concerning the doctrine, and the prerequisites for application of the doctrine – an ambiguous or inconspicuous plan exclusion – are not present?

3. Should this Court review the denial of benefits in an ERISA case in which two of the Respondents – Group & Pension Administrators, Inc. and Connecticut General Life Insurance Company – cannot be held liable for benefits to Petitioner because they did not serve as plan administrator and were merely third-party claims administrators of Respondent CROSSMARK's self-funded plan?

PARTIES TO THE PROCEEDINGS BELOW

Respondents CROSSMARK, Inc. and Group & Pension Administrators, Inc., make this Disclosure of Corporate Affiliations and Corporate Interest pursuant to SUP. CT. R. 29.6, and would respectfully show the Court as follows:

A. Petitioner is Neva Murray, Individually and as Guardian of Hugh Murray, Ward.

B. Respondents are CROSSMARK, Inc.; Connecticut General Life Insurance Company; and Group & Pension Administrators, Inc.

RULE 29.6 STATEMENT

CROSSMARK Holdings, Inc. is the parent corporation to Respondent CROSSMARK, Inc. ("CROSSMARK"). There are no publicly held corporations that own 10% or more of CROSSMARK's stock.

GPA Holdings, Inc. is the parent corporation to Respondent Group & Pension Administrators, Inc. ("GPA"). There are no publicly held corporations that own 10% or more of GPA's stock.

Respondent Connecticut General Life Insurance Company ("CIGNA") identifies the following potentially interested parties who are related to it: CIGNA Corporation, which is a publicly held corporation, CIGNA Holdings, Inc., and Connecticut General Corporation.

Aside from the subsidiary and affiliate relationships described above, there are no publicly owned corporations, not a party to the appeal, with a financial interest in the outcome of this appeal.

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INTRODUCTION

Petitioner Neva Murray is a participant in Respondent CROSSMARK, Inc.'s ("CROSSMARK") employee welfare benefit plan ("Plan"), which, since at least 1997, has excluded coverage for work-related injuries. Petitioner enrolled her husband in the Plan as a dependent on March 29, 2000. Petitioner admits her husband was injured while on the job in February 2001 and that the Plan contains an exclusion for work-related injuries. These facts are fatal to Petitioner's claim, and it was on this basis that Respondents GPA and CIGNA, the claims administrators for CROSSMARK's Plan during the relevant time period, denied benefits.

Recognizing the effect of these undisputed facts, Petitioner turns to arguments not presented to the Court of Appeals or the District Court and relies on purported facts not supported by the appellate record. Petitioner argues that even if the Plan document grants a claims administrator discretion, the abuse of discretion standard should not necessarily apply. Petitioner requests that this Court overturn its decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), 17 years after it was decided and during which time nearly every employer in the United States that offers benefits to its employees has followed the Court's direction in deciding the amount of discretion to confer to plan fiduciaries. Petitioner requests such relief for the first time in this Court, and she does so in the absence of any conflict among the circuits on this issue.

Petitioner also requests that the Court decide whether the doctrine of reasonable expectations applies in all ERISA denial of benefits cases. Contrary to Petitioner's argument, there is not a split among the circuits and this case does not provide an appropriate platform for addressing any such alleged conflict. In addition, the Plan exclusion at issue was

conspicuous and unambiguous. For the doctrine of reasonable expectations to apply in any circuit, a finding of either inconspicuousness or ambiguity is required. Thus, even if this case otherwise provided a vehicle for deciding whether the doctrine of reasonable expectation applies, the facts of the case do not support full consideration of the issue.

For these reasons and those stated below, Respondents respectfully submit that the Court deny Petitioner's petition.

STATEMENT OF THE CASE

I. BACKGROUND FACTS.

CROSSMARK is a professional services company that helps consumer packaged goods manufacturers and retailers reach their performance goals. CROSSMARK employs more than 15,000 employees world-wide. CROSSMARK was formed in 1995 through a merger of three sales and marketing companies. CROSSMARK and its predecessors have sponsored a health and welfare employee benefit plan for its employees since its inception. The CROSSMARK medical Plan is a self-funded plan that provides medical, prescription drug and vision benefits to Plan participants and beneficiaries by making payments or reimbursements pursuant to the terms of the Plan Document and Summary Plan Description ("SPD").[1] Resp. App. 3b, 4b, 9b.

Petitioner is employed with CROSSMARK, and has participated in CROSSMARK's medical Plan since 1996. Petitioner signed an enrollment application stating that she

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[1] Courts have recognized that the plan document and SPD are often the same document for a self-insured plan like CROSSMARK's Plan. *See Sunbeam-Oster Co. Group Benefits Plan for Salaried and Non-Bargaining Hourly Employees v. Whitehurst*, 102 F.3d 1368, 1375 (5th Cir. 1996).

agreed to be bound by the terms and conditions of the Summary Plan Description and Plan Document.

CROSSMARK is the Plan administrator, but it delegates claims administration to a third-party claims administrator who has the discretion and authority to make benefit determinations. Pet. App. 2. In 1997, GPA became the claims administrator for the Plan. As administrator, GPA determined which claims for benefits should be paid under the terms of the SPD. Pet. App. 2; Resp. App. 8b, 9b. On March 29, 2000, Petitioner enrolled her husband, Hugh Murray, as a dependent beneficiary in the Plan because he started his own pest control business, Admiral Pest Control, Inc., with a partner and no longer had other health insurance. Pet. App. 2.

On March 1, 2001, CROSSMARK replaced GPA with CIGNA as claims administrator. Thus, effective March 1, 2001, CIGNA exercised its discretion to make benefit determinations under the Plan for claims occurring on or after March 1, 2001. Pet. App. 2.

II. Petitioner Had Access To The SPD, Which Has Always Excluded Charges Incurred For Work-Related Injuries.

When Petitioner enrolled in the Plan, the SPD was available to all participants through CROSSMARK's Human Resources Department. In 1999, CROSSMARK distributed the SPD to participants, including Petitioner, by posting it in CROSSMARK 's Public Folders on its computer system. Petitioner had access to the SPD through her computer at her work station and CROSSMARK informed Petitioner how to access the SPD on its computer system. Petitioner also knew she could call GPA, access GPA's website, contact CROSSMARK's Benefits Department, or call CIGNA (once

it became the claims administrator) if she had questions about the Plan or SPD.

Since at least 1997, when GPA became the CROSSMARK Plan's claims administrator, the Plan has excluded from coverage any charges arising out of any occupation for wage or profit. Specifically, the SPD stated:

> The following exclusions and limitations apply to expenses incurred by all Covered Persons:
>
> 3. Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law.

Resp. App. 10b (referred to herein as the "work-related" exclusion). This work-related exclusion is a common exclusion in employee benefit plans under ERISA.

When CIGNA replaced GPA as the claims administrator, certain amendments to the schedule of benefits became effective on March 1, 2001. Resp. App. 24b, 25b. In January 2001, CROSSMARK gave its employees notice of these material Plan changes through a Summary of Material Modifications ("SMM"), as required by ERISA, Section 104(b)(1) (29 U.S.C. § 1024(b)(1)), which were set forth in an Enrollment Guide and Benefits Summary. Resp. App. 24b, 25b. CROSSMARK did not materially change the work-related exclusion. Accordingly, the SMM did not reference the exclusion. In July 2001, CROSSMARK issued an amended SPD, which incorporated the changes that had been

previously explained in the SMM.[2] Like GPA had done, CIGNA provided a "form" SPD for CROSSMARK's use; therefore, some of the language and format between the GPA-administered SPD ("GPA SPD") and the CIGNA-administered SPD ("CIGNA SPD" or "amended SPD") may have differed where the Plan terms did not change. Like the GPA SPD, the amended SPD contains a work-related injury exclusion:

> No payment will be made for expenses incurred for you or any one of your Dependents:
>
> - for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.

Resp. App. 2b.

III. PETITIONER'S HUSBAND SUFFERED A WORK-RELATED INJURY.

On February 12, 2001, Mr. Murray fell through a ceiling from an attic onto a concrete floor while performing his pest control job duties at a customer's house for profit. Resp. App. 19b, 20b.

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[2] Under ERISA, Section 104(b)(1) (29 U.S.C. § 1024(b)(1)), a plan administrator is only required to issue an amended summary plan description which integrates all plan amendments every five years. Even when a plan administrator does issue an amended plan, a plan administrator has 210 days after the end of the plan year for which the change is adopted to issue the amended summary plan description. This means that, although CROSSMARK was not required to issue an amended SPD until January 2004, since it did so, CROSSMARK had until September 26, 2002 to provide Petitioner an amended SPD. CROSSMARK distributed the amended SPD to participants and beneficiaries, including Petitioner, in July 2001 - well before ERISA's required deadline. Resp. App. 25b.

Once GPA began receiving claims arising out of Mr. Murray's February 12, 2001 accident, it initiated an investigation to determine whether those claims were covered by the Plan. As part of its investigation, on May 11, 2001, GPA sent Petitioner a request for more information about Mr. Murray's injuries. Resp. App. 11b, 12b, 13b. On May 29, 2001, Petitioner submitted a statement to GPA and CROSSMARK in connection with GPA's eligibility determination, and admitted--in her own writing--that Mr. Murray's injuries were work-related:

> Was the accident related in any way to your work? ***Yes***
>
> If yes, please explain: ***Was on job.... Self employed—Admiral Pest Control 7126 Eckhert Rd. Ste 211, San Antonio; 78238.***

Resp. App. 11b, 12b, 13b. ("May 29, 2001 statement").

IV. THE ADMINISTRATORS CORRECTLY DENIED CLAIMS ARISING FROM MR. MURRAY'S WORK-RELATED INJURIES.

After GPA (a) received Petitioner's May 29, 2001 statement in which she stated that Mr. Murray's injuries were work-related, and (b) reviewed the Plan terms, GPA determined that claims arising from Mr. Murray's injury were excluded from coverage under the Plan's work-related exclusion. In early June 2001, GPA began sending denial of benefits notices to Petitioner, indicating that Mr. Murray's injuries were not covered because "CHARGES INCURRED AS A RESULT OF AN ON THE JOB INJURY OR ILLNESS ARE DENIED ACCORDING TO THE MAJOR MEDICAL EXCLUSIONS IN YOUR SUMMARY PLAN DESCRIPTION." CROSSMARK also instituted its own investigation and likewise concluded that Mr. Murray's

injuries were expressly excluded under the Plan's terms. Pet. App. 3.

Because of the change in the entity administrating claims, Petitioner submitted claims for expenses incurred after March 1, 2001 to CIGNA. Unlike GPA, CIGNA utilizes what it calls a "pay and chase" system of claims administration. Consistent with this system, CIGNA initially paid Petitioner based upon the claims received and then instituted an investigation. CIGNA paid approximately $90,000 in benefits, but after investigation, determined that Mr. Murray's claims were barred by the work-related exclusion. Resp. App. 14b, 15b. Petitioner contested the denials and, in its role as claims administrator at that time, CIGNA affirmed the decision to deny Mr. Murray's benefit claims. Resp. App. 16b, 17b; Pet. App. 4.

V. PROCEDURAL HISTORY.

Challenging the administrators' decisions to deny claims arising from Mr. Murray's work-related injuries, Petitioner filed this lawsuit against Respondents, asserting only a denial of benefits claim under Section 502(a)(1)(B) of ERISA (29 U.S.C. § 1132(a)(1)(B)) in her Second Amended Complaint.

CROSSMARK and GPA moved for summary judgment in the District Court on the grounds that Respondents' denial of benefits to Mr. Murray based on the unambiguous language of the Plan exclusions was not an abuse of discretion. CIGNA joined the motion. Petitioner also moved for partial summary judgment. Pet. App. 9. The District Court denied Petitioner's motion for partial summary judgment and granted a complete summary judgment in favor of GPA and CIGNA. Pet. App. 9-22.

The District Court granted summary judgment to CROSSMARK on Petitioner's denial of benefits claim under ERISA, Section 502(a)(1)(B). In its summary judgment

Order, the District Court determined that (i) the work-related exclusion was unambiguous, and (ii) it was undisputed that Mr. Murray's injuries were work-related. The District Court also noted that Petitioner did "not dispute that the plan administrator had discretionary authority to construe that plan or that the administrator's decision was not arbitrary or capricious." Pet. App. 13. Based on the undisputed facts, the District Court concluded that the administrators did not abuse their discretion in denying Mr. Murray's claim for benefits arising from his work-related injuries because such claims were excluded by the plain terms of the SPD. In its decision, the District Court rejected Petitioner's arguments that (i) the Plan exclusion was an affirmative defense that was not pled and was waived, and (ii) the reasonable expectations doctrine compelled judgment for Petitioner. However, the District Court determined that Petitioner could amend her Complaint to assert a claim against CROSSMARK for statutory penalties under ERISA, Section 502(c)(1) (29 U.S.C. §1132(c)(1)), for alleged failure to timely provide her an SPD upon her request. The parties settled Petitioner's Section 502(c)(1) claim, it was dismissed with prejudice, and was not part of her appeal to the Fifth Circuit. Pet. App. 7.

In Petitioner's appeal to the Fifth Circuit, she raised the same arguments as she did at the District Court. Petitioner did not contest that the appropriate standard of review for her Section 502(a)(1)(B) claim was abuse of discretion. The Fifth Circuit concluded that (i) the District Court did not err in concluding that the work-related exclusion defense was not waived, and (ii) the District Court did not err in concluding that the denial of benefits under the unambiguous terms of the work-related exclusions was neither arbitrary nor capricious. Pet. App. 5-6.

VI. PETITIONER'S MATERIAL MISREPRESENTATIONS.

Consistent with Rule 15.2 of this Court's Rules, Respondents note Petitioner's material misrepresentations of the appellate record. The judgment of the District Court and the Fifth Circuit was based on cross-motions for summary judgment, and only those facts contained in the summary judgment record may be considered on appeal to this Court. Petitioner, however, proffers several alleged "facts" that are not supported by evidence and are not contained in the appellate record.

For example, Petitioner states on page 3 of her Petition that "once CIGNA assumed administrative duties on March 1, 2001, it administered the Crossmark plan without benefit of any governing documents – whether SPD or plan – until July, 2001." This is a misstatement of the evidence. As stated above, the record demonstrates that when CIGNA became the claims administrator on March 1, 2001, it administrated claims under the GPA SPD and the SMM until the Plan was amended in July 2001, at which time CIGNA used the CIGNA SPD – which contained a substantively identical work-related exclusion to the GPA SPD.

Similarly, Petitioner incorrectly asserts that "CIGNA, months after learning of Mr. Murray's extensive claims, drafted its plan, separated out the worker's compensation and work-related exclusions into two separate exclusions, and placed the work-related exclusion as the first-listed one." Pet. 5. This statement is untrue and does not appear anywhere in the appellate record. In fact, the CIGNA SPD was drafted with no regard to Petitioner's claims and was a form used by CIGNA that contained the same work-related exclusion as the GPA SPD; the CIGNA SPD merely listed the exclusion separately rather than in a single paragraph with the workers' compensation exclusion like the GPA SPD.

Additionally, on Page 6 of the Petition, Petitioner states:

> Respondents indicated, in internal communications, that no administrator was to pay any benefits for Hugh Murray and instructed adjusters to deny all claims, in an apparent decision that all future health care needs by Mr. Murray related back to his accident. Claims for Mr. Murray's gastrointestinal and cardiac problems were thus denied.

This purported "fact" appears nowhere in the appellate record. In fact, Petitioner first attempted to make such a claim after the District Court granted summary judgment to Respondents. The District Court granted CROSSMARK's motion to strike this pleading, and Petitioner did not appeal the District Court's decision.

These misstatements by Petitioner should not be considered by this Court when deciding whether to grant Petitioner's petition.

REASONS THE WRIT SHOULD BE DENIED

I. THE COURT SHOULD DECLINE TO CONSIDER PETITIONER'S BELATED CHALLENGE TO ERISA'S ABUSE OF DISCRETION STANDARD OF REVIEW.

In her first question presented for review, Petitioner requests that this Court reconsider its holding in *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 115 (1989), that the appropriate standard of review in a denial of benefits case of an ERISA administrator with discretion is abuse of discretion. According to Petitioner, this standard of review framework set out in *Firestone Tire* has proven untenable. To support this argument, Petitioner proffers several misleading and incorrect factual and legal assertions.

A. Petitioner has waived any arguments relating to the appropriate standard of review.

Petitioner did not dispute in the District Court or the Court of Appeals that the abuse of discretion standard of review applied in this case. In her Second Amended Complaint, Petitioner set forth the standard alleging denial of her benefit claims as "arbitrary and capricious" and did not challenge or complain of the application of that standard to her claims. Moreover, Petitioner did not appeal the District Court's application of the abuse of discretion standard of review to the Court of Appeals. Neither the District Court nor the Court of Appeals was presented with an opportunity to consider the challenge to the standard of review Petitioner now urges in this Court.

As a result, Petitioner's challenge to ERISA's abuse of discretion standard of review is waived and should not be considered by the Court. *See United States v. Williams*, 504 U.S. 36, 41 (1992); *Lawn v. United States*, 355 U.S. 339, 362 n.16 (1958); *California v. Taylor*, 353 U.S. 553, 556 n.2 (1957).

B. There is no Circuit Court split or "rising judicial chorus" that would justify reconsideration of the well-established standard of review framework established by the Court in *Firestone Tire*.

As a threshold to her argument, Petitioner relies on Justice Ginsburg's concurrence in *Aetna Health Inc. v. Davila,* 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring), and asserts "it is time to recognize 'the rising judicial chorus urging that Congress and this Court revisit what is an unjust and increasingly tangled ERISA regime.'" Pet. 8. Petitioner then implies that *Aetna Health* supports the proposition that one of the "unjust and tangled ERISA regime" issues that should be reviewed by the Court is the appropriate standard of review

to be applied in a denial of benefits case under ERISA. Petitioner's far-fetched argument is not supported by the law or facts of this case.

First, *Aetna Health* did not involve the appropriate standard of review in a denial of benefits case; nor did it analyze a denial of benefits. Second, Justice Ginsburg's concurrence addressed a potential conflict between ERISA's broad preemptive scope and the limited equitable relief allowed for a claim asserted under Section 502(a)(3) of ERISA. Because Petitioner did not assert any Section 502(a)(3) claims or dispute ERISA's preemptive effect of her state law claims in this case, her reliance on Justice Ginsburg's concurrence in *Aetna Health* is misplaced.

Third, in the Court's unanimous decision in *Aetna Health*, the Court reiterated the well-established *Firestone Tire* standard of review analysis, without referencing any alleged conflict among the Circuits: "Any dispute over the precise terms of the plan is resolved by a court under a *de novo* review standard, unless the terms of the plan 'giv[e] the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.'" *Aetna Health*, 542 U.S. at 210 (quoting *Firestone Tire*, 489 U.S. at 115).

Fourth, Petitioner's contention is not supported by any case law. All circuit courts of appeals have consistently and uniformly followed *Firestone Tire*. *See, e.g., Madera v. Marsh USA, Inc.*, 426 F.3d 56, 63–64 (1st Cir. 2005); *Gibbs v. CIGNA Corp.*, 440 F.3d 571, 575 (2d Cir. 2006); *Vitale v. Latrobe Area Hosp.*, 420 F.3d 278, 281–82 (3d Cir. 2005); *Colucci v. Agfa Corp. Severance Pay Plan*, 431 F.3d 170, 175-76 (4th Cir. 2005), *cert. denied*, 164 L.Ed. 2d 815 (2006); *Mello v. Sara Lee Corp.*, 431 F.3d 440, 443–44 (5th Cir. 2005); *McCartha v. Nat'l City Corp.*, 419 F.3d 437,

441-42 (6th Cir. 2005); *Ruiz v. Cont'l Cas. Co.*, 400 F.3d 986, 989 (7th Cir. 2005); *Butts v. Cont'l Cas. Co.*, 357 F.3d 835, 838 (8th Cir. 2004); *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d 869, 874–75 (9th Cir. 2004); *Allison v. UNUM Life Ins. Co. of Am.*, 381 F.3d 1015, 1021 (10th Cir. 2004); *Torres v. Pittston Co.*, 346 F.3d 1324, 1328–29 (11th Cir. 2003).

C. *Firestone Tire* does not require deference to the plan administrator's decision in every case.

Petitioner incorrectly claims that a court is constrained in reviewing a benefit denial, because "in all but the rare case, lower federal courts following this Court's decision in *Firestone Tire & Rubber Co.*, must defer to the administrator's decision." Pet. 8. This Court did not hold that a lower court "must defer" to the administrator's decision. To the contrary, the Court held that "a denial of benefits . . . is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire*, 489 U.S. at 115.

Even under the abuse of discretion analysis, the plan administrator's decision must be (i) legally correct, and (ii) if it is not legally correct, must not constitute an abuse of discretion. *Vercher v. Alexander & Alexander Inc.*, 379 F.3d 222, 227 (5th Cir. 2004). To determine whether a plan administrator's decision is legally correct, a court considers: (1) whether the administrator has given the plan a uniform construction; (2) whether the interpretation is fair and reasonable, and (3) whether unanticipated costs would result from a different plan interpretation. *Id.* at 228. In determining whether the plan interpretation was an abuse of discretion, courts analyze whether it is an interpretation that

a reasonable person could have reached. *See, e.g., McCall v. Burlington Northern/Santa Fe Co.*, 237 F.3d 506, 512 (5th Cir. 2000), *cert. denied*, 534 U.S. 822 (2001). Thus, a court reviewing a benefit denial under an abuse of discretion standard must analyze the decision and determine whether it was reasonable.

D. Alleged procedural violations of ERISA do not change the standard of review.

Petitioner contends that alleged procedural violations of ERISA should necessarily trigger *de novo* review, notwithstanding *Firestone Tire*. She predicates her argument on false assertions.

First, Petitioner incorrectly argues that "since ERISA precludes statutory penalties, ERISA administrators have an incentive to deny all claims and force claimants to enter court." Pet. 8. To the contrary, ERISA *provides* for statutory penalties -- ERISA does not *preclude* statutory remedies. Indeed, in the District Court's summary judgment Order in this case, the court specifically allowed Petitioner to amend her Complaint and add a claim for statutory penalties under Section 502(c)(1)(B), which she did. Further, plan administrators do not "have an incentive to deny all claims and force claimants to enter court" because plan administrators have fiduciary duties under ERISA. ERISA requires that "a fiduciary shall discharge his duties with respect to a plan . . . in accordance with the documents and instruments governing the plan . . . " Section 404(a)(1)(b) (29 U.S.C. § 1104(a)(1)(D)). Fiduciaries can be held individually liable under ERISA for a breach of their duties. *See, e.g.*, Sections 502(a)(2), 502(a)(3).

Second, Petitioner alleges that judicial "deference is given to the plan administrator even if the administrator itself has grossly flouted ERISA's procedural safeguards for

employees/beneficiaries." Pet. 8. This allegation is without merit. There is no evidence in this case that the Plan administrator "grossly flouted ERISA's procedural safeguards." As previously noted, ERISA provides remedies for procedural violations, which Petitioner asserted in this case and the parties settled. In addition, courts have recognized that a procedural violation of ERISA may give rise to a substantive remedy (but not that it changes the standard of review) if the procedural violation is "continuous and amounts to substantive harm." *Hines v. Mass. Mut. Life Ins. Co.*, 43 F.3d 207, 211 (5th Cir. 1995). This case does not fit within the limited exception for a continuous violation that amounts to substantive harm. The District Court correctly determined that an alleged failure to furnish the SPD to Petitioner did not affect her substantive rights or the Plan administrator's benefit decision. Pet. App. 16. The District Court reasoned that Petitioner "cannot offer evidence that the plan administrator's decision was the product of an arbitrary decision or the plan administrator's whim. Plaintiffs are unable to overcome the fact that Mr. Murray was injured during the course of his employment, and the plan clearly excluded such injury from coverage." Pet. App. 16.

With respect to the settled alleged procedural violation, even if Petitioner undisputedly had received the SPD sooner, there was nothing she could have done to change the outcome in this case, because the Plan clearly excluded Mr. Murray's injury from coverage. As the District Court noted, the Eighth Circuit's decision in *Tillery v. Hoffman Enclosures, Inc.*, 280 F.3d 1192 (8th Cir. 2002) is instructive. Pet. App. 16

There "[t]he Tillerys also question whether they ever received a copy of the SPD. Assuming they did not, they fail to explain how such an oversight affected their substantive rights or the decision of the plan administrator." 280 F.3d at 1198. The administrator was required to discharge its duties

in accordance with the Plan terms, which specifically excluded work-related injuries from coverage. To ignore the exclusion would cause the administrator to breach its fiduciary duties.

See also Section 504(a)(1)(D) (29 U.S.C. § 1104(a)(1)(D)) ("a fiduciary shall discharge his duties with respect to a plan . . . in accordance with the documents and instruments governing the plan.").[3]

Next, Petitioner misleadingly posits the issue that "this Court has never explicitly decided the important question of whether backdated or post-hoc instruments may exclude claims for benefits under an ERISA welfare plan, as Respondents have done here. Thus, this Court has also never decided whether an abuse of discretion review is appropriate under these circumstances." Pet. 10. The issue posited by Petitioner is not presented by the facts in this case. As previously explained, Petitioner's contention that there was no SPD in this case is false. The District Court and the Fifth Circuit recognized that there was a Plan document and SPD in effect at all times. Pet. App. 2, 15-16. Additionally, the issue is waived because Petitioner never presented the issue to the lower courts. Further, Petitioner's repeated complaints concerning the alleged failure to provide her with an SPD were resolved by settlement in the District Court, and are not properly before this Court.

Disingenuously conflating two very distinct theories, Petitioner states "ERISA regulations require that plans

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[3] Although Petitioner stated in her Petition that "the Fifth Circuit affirmed that decision [that the alleged failure to provide her an SPD did not amount to substantive harm] for essentially the reasons stated below" (Pet. 10), she did not appeal this issue to the Fifth Circuit, the Fifth Circuit did not analyze this issue, and it is waived.

provide notice in writing of the specific reasons for such denial, written in the manner calculated to be understood by the participant when denying benefits." Pet. 12 (citing ERISA Section 501, 29 U.S.C. § 1131). Petitioner next claims that the Fifth Circuit determined that ERISA's "specific reasons" for denial requirements were satisfied by Respondents by their general reference to "plan terms" in their answer to Petitioner's Complaint. Petitioner then concludes that the Fifth Circuit's decision "directly conflicts with the statutory scheme and with other circuits." Pet. 12. Petitioner's argument is wrong.

First, Section 501 refers to the denial of benefits notice issued by the plan administrator. Petitioner never claimed in this lawsuit that the Explanation of Benefits ("EOB") denying Mr. Murray's claims did not satisfy Section 501. She could not do so. The EOBs clearly explained that Mr. Murray's claims for benefits were denied because "CHARGES INCURRED AS A RESULT OF AN ON THE JOB INJURY OR ILLNESS ARE DENIED ACCORDING TO THE MAJOR MEDICAL EXCLUSIONS IN YOUR SUMMARY PLAN DESCRIPTION." Second, neither the District Court nor the Fifth Circuit ever addressed whether the EOBs denying Petitioner's claims complied with ERISA because Petitioner never raised this issue. Rather, Petitioner intermingles this new argument with her mistaken assertion that a plan exclusion is an affirmative defense that a plan administrator must specifically plead in its answer or it is waived, which is the point that she appealed to the Fifth Circuit.

Third, in rejecting Petitioner's affirmative defense/waiver argument, the Fifth Circuit concluded that the work-related exclusions were unambiguous in this case, and that the District Court did not err in concluding that the work-related exclusion defense was not waived because Petitioner was

neither surprised nor prejudiced by Respondents' reliance on the exclusion. The Fifth Circuit affirmed that:

> The record reflects that Petitioner was on notice of the work-related exclusion in the SPD prior to the filing of the lawsuit. Petitioner concedes that the defendants asserted the work-related exclusion in their June 11, 2003 Motion to Limit Discovery, filed over 11 months before the trial setting. Furthermore, defendants affirmatively pled in their answer to Murray's Second Amended Complaint that the claims were denied in accordance with the terms and conditions of the Plan.

Pet. App. 5. Additionally, Petitioner testified that she understood nearly two years before she filed her lawsuit that Mr. Murray's claims were denied because his claims "arose out of an injury that occurred in the course and scope of an occupation for wage or profit." Resp. App. 20b, 21b, 22b.

E. The outcome of this case would be the same under *de novo* review.

Even if a court reviewed Petitioner's denial of benefits claim under a *de novo* standard of review, the decision to deny benefits is correct based on the plain and unambiguous terms of the Plan. The Plan specifically excludes from coverage injuries arising out of or in the course and scope of employment for wage or profit. Resp. App. 2b, 10b. Petitioner submitted a handwritten statement to the claims administrator specifically stating that "yes," Mr. Murray's claims were incurred in the course and scope of employment, and testified that Mr. Murray's injuries occurred during his occupation for wage or profit. Resp. App. 11b, 12b, 13b, 19b, 20b. Given these undisputed facts, applying a *de novo* standard of review would not change the outcome in this case.

II. THE COURT SHOULD DECLINE TO CONSIDER PETITIONER'S CHALLENGE TO THE REASONABLE EXPECTATIONS DOCTRINE.

Petitioner claims that the Fifth Circuit erred in its "rejection (by affirmation) of the reasonable expectations doctrine," and that the courts of appeals are divided over whether ERISA plans must be interpreted in accordance with the doctrine and ERISA plan administrators' decisions reviewed under the doctrine. Pet. i. As the District Court noted, under the doctrine of reasonable expectations, "even an unambiguous exclusion may be unenforceable unless it is sufficiently clear, plain and conspicuous to overcome a layperson's reasonable expectations." Pet. App. 14 (quoting *Saltarelli v. The Bob Baker Group Med. Trust*, 35 F.3d 382, 385-87 (9th Cir. 1994)).

A. The District Court correctly concluded that the reasonable expectations doctrine would not apply to the work-related exclusion in this case.

Petitioner argues that the District Court erroneously concluded (and the Fifth Circuit erroneously affirmed the conclusion) that the reasonable expectations doctrine would not apply in this case. This Court's Rules provide that "[a] petition for a writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings . . .." SUP. CT. R. 10. In this case, there are no exceptional circumstances that would justify further review of the District Court's conclusion that, "even if the Court adopted the doctrine of reasonable expectations, the exclusion was plain, clear and sufficiently conspicuous." Pet. App. 16.

Consistent with the District Court's conclusion, the courts of appeals that have considered the reasonable expectations doctrine in the context of an ERISA plan have, either explicitly or implicitly, held that application of the doctrine

requires a threshold determination that the plan exclusions are not sufficiently "clear, plain and conspicuous" or are ambiguous. *Saltarelli*, 35 F.3d at 387 (applying the doctrine because the exclusion was not "clear, plain and conspicuous"); *see also Bynum v. CIGNA Healthcare of N.C., Inc.*, 287 F.3d 305, 313-14 (4th Cir. 2002) (if a plan is ambiguous, court will then interpret it in accordance with the insured's reasonable expectations); *Pirkheim v. First Unum Life Ins.*, 229 F.3d 1008, 1011 (10th Cir. 2000) ("Where the insuring clause or exclusionary provision is conspicuous, clear and unequivocal, we conclude application of the common law doctrine of reasonable expectation is improper"); *McClure v. Life Ins. Co. of N. Am.*, 84 F.3d 1129, 1136 (9th Cir. 1996) ("if the exclusionary language . . . in question is conspicuous it would bar recovery. . ."); *Babikian v. Paul Revere Life Ins. Co.*, 63 F.3d 837, 842 (9th Cir. 1995) (plaintiff had no reasonable expectation that her plan benefits would vest because plan provisions were "clear, plain and conspicuous"); *Wheeler v. Dynamic Eng'g, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995) ("Where a term is ambiguous," court looks at reasonable expectations); *Winters v. Costco Wholesale Corp.*, 49 F.3d 550, 555 (9th Cir.), *cert. denied*, 516 U.S. 908 (1995) (plaintiff "had no objectively reasonable expectation of coverage" for a medical procedure because plan's exclusionary clauses were conspicuous, plain and clear); *Peterson v. Am. Life & Health Ins. Co.*, 48 F.3d 404, 411-12 (9th Cir.), *cert. denied*, 516 U.S. 942 (1995) (reasonable expectations doctrine does not apply because exclusion of bypass surgery was not ambiguous and was sufficiently conspicuous).

1. The SPD Exclusions are clear, plain and conspicuous.

The District Court concluded that the work-related exclusions were sufficiently clear, plain and conspicuous to survive any reasonable expectations attack. Both the District Court and the Fifth Circuit concluded that the work-related exclusions are unambiguous. Pet. App. 5, 16.

Both SPDs describe the exclusion in language that is calculated to be understood by an average plan participant. Specifically, the GPA SPD clearly explains that, "Charges arising out of or in the course of any occupation for wage or profit," are not covered by the Plan. Resp. App. 10b. Similarly, the CIGNA SPD states plainly that: "No payment will be made for expenses incurred for you or any of your Dependents . . . for or in connection with an injury arising out of, or in the course of, any employment for wage or profit." Resp. App. 2b.

In addition, the exclusions are in no way "minimized, rendered obscure or otherwise made to appear unimportant" and they are "described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits." 29 C.F.R. § 2520.102-2(b). In the GPA SPD, the Table of Contents identifies, "MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS" in the same manner as the section for "MAJOR MEDICAL EXPENSE BENEFITS" and all other Table of Content titles. Resp. App. 5b, 6b. Turning to the section on Exclusions, the page is titled, **"MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS"** and, under **"GENERAL EXCLUSIONS AND LIMITATIONS"** has a numbered list of items that are not covered under the Plan. Resp. App. 10b. The "occupation for wage or profit" exclusion is the third listed,

is described in a separate paragraph, and is written in the same font, type and style used to describe the Plan benefits and all other provisions in the SPD. Resp. App. 10b.

Similarly, the CIGNA SPD's Table of Contents references "General Limitations" in the same manner used to identify other SPD sections, including the preceding sections on benefits. Resp. App. 1b. In the **"GENERAL LIMITATIONS MEDICAL AND VISION BENEFITS"** section, the exclusion for charges incurred in "any employment for wage or profit" is set forth in a separate, bullet pointed paragraph. Resp. App. 2b. In fact, it is the very first exclusion listed. Finally, the font, style and type used for the exclusion are the same used to describe benefits and are used throughout the SPD.

Based on the language in these SPDs, even applying *Saltarelli*'s reasonable expectations doctrine, the District Court's conclusion was sound. In *Saltarelli*, in contrast to the exclusions in this case, the exclusion at issue was found in the middle of the plan's Definitions section and, even in that section, understanding the exclusion required a coordinated reading of three separate definitions. 35 F.3d 382, 385 (9th Cir. 1994). Although the plan had a section entitled, "Exclusions and Limitations," unlike here, the pre-existing condition exclusion was not identified in that section. *Id.* Significantly, the language and placement of the CROSSMARK SPD exclusions have none of the flaws that existed with the pre-existing condition exclusion in *Saltarelli*. *See also Babikian*, 63 F.3d at 842 (finding that plaintiff had no reasonable expectation that her plan benefits would vest because plan provisions were "clear, plain and conspicuous"); *Winters*, 49 F.3d at 555 (holding that plaintiff "had no objectively reasonable expectation of coverage" for a medical procedure because plan's exclusionary clauses, which were

identified in appropriate Table of Contents headings, were conspicuous, plain and clear).

2. The GPA SPD's work-related exclusion is not ambiguous.

Both the District Court and the Fifth Circuit concluded that the work-related exclusion in both SPDs was unambiguous. Pet. App. 5, 16. Nonetheless, Petitioner argues that the GPA SPD exclusion is ambiguous "as to whether it applies to worker's compensation coverable injuries or all work-related injuries" and that the exclusion should, therefore, be construed in accordance with her expectations of coverage. Pet. 15. This argument is unpersuasive given the clear, unambiguous language of the GPA SPD.

The Sixth Circuit rejected the same argument in *Marquette Gen. Hosp. v. Goodman Forest Industries*, 315 F.3d 629 (6th Cir. 2003). In *Marquette*, the Sixth Circuit applied ERISA to the same type of work-related exclusion at issue in this case. *Id.* at 631-32. The plan in that case, like the GPA SPD, excluded "claims arising out of, or in any course of any occupation or employment for wage or profit or claims for which the covered person is entitled to benefits under any Workers' Compensation or occupational disease law . . .." *Id.* at 631-32. The Sixth Circuit easily rejected the plaintiffs' argument that this clause was ambiguous and that the "or" in the exclusion should be read as "and." *Id.* at 632-33. The Sixth Circuit explained:

> This exclusion is written in the disjunctive; one exclusion does not depend on the other, nor does one determine the other. Contrary to Plaintiffs' assertion, the word **or** does not also mean **and**. Any other reading constrains the clear meaning of the language. As this court has previously held, ERISA plans should

> be interpreted "according to their plain meaning, in an ordinary and popular sense."

Id. at 633 (citation omitted) (emphasis in original). Thus, the Sixth Circuit found that the denial of benefits was "rational" and "neither arbitrary or capricious" and upheld the district court's summary judgment. *Id.* Likewise, the determination by the District Court and Fifth Circuit that the exclusion is unambiguous is proper.

3. The CIGNA SPD's pre-existing condition exclusion is not ambiguous and Petitioner waived this argument.

Attempting to create ambiguity where none exists, Petitioner contends that the work-related exclusion in the CIGNA SPD is ambiguous because the SPD also has a pre-existing condition exclusion. Pet. 15.

Petitioner's pre-existing condition argument fails at the outset because she did not raise this argument at the administrative review level or in the District Court. It is well established that, absent exceptional circumstances that would result in a miscarriage of justice, a party cannot appeal a summary judgment based on theories or factual claims that were not presented to the trial court or court of appeals. *See Williams*, 504 U.S. at 41; *Lawn,* 355 U.S. at 362 n.16; *California v. Taylor*, 353 U.S. at 556 n.2.

Moreover, because the administrators did not rely on a preexisting condition exclusion to deny charges resulting from Mr. Murray's work-related injuries, Petitioner's argument fails. In short, the exclusions are conspicuous and unambiguous and, under well-established ERISA precedent, the District Court correctly granted summary judgment.

B. The Fifth Circuit did not reject the reasonable expectations doctrine.

Petitioner's argument that there is a split of authority over application of the reasonable expectations doctrine is wrong. The Fifth Circuit's decision in this case does not reject the reasonable expectations doctrine. The District Court's summary judgment Order did not adopt the reasonable expectations doctrine. Pet. App. 15. It nonetheless analyzed whether the doctrine, if recognized, would save Petitioner's claim. Pet. App. 15-17. In its decision affirming the District Court's summary judgment, the Fifth Circuit did not specifically analyze Petitioner's reasonable expectations argument. The Fifth Circuit concluded that the work-related exclusions were "unambiguous" and affirmed the District Court's summary judgment on Petitioner's "denial of benefits claim essentially for the well-stated reasons provided by the district court." Pet. App. 5-6.

C. The courts of appeals are not split with respect to the reasonable expectations doctrine.

Petitioner claims that the Second Circuit, Third Circuit,[4] Fourth Circuit and Ninth Circuit have accepted the reasonable expectations doctrine, that the Fifth Circuit and Tenth Circuit have found it inapplicable to ERISA, and that the Seventh Circuit has not decided the issue. Pet. 14-15. A careful

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[4] The 1992 Third Circuit opinion upon which Petitioner relies involves a different legal question. *Henglein v. Informal Plan for Plant Shutdown Benefits for Salaried Employees*, 974 F.2d 391 (3d Cir. 1992). Unlike this case, *Henglein* did not address the standards for reviewing the meaning of plan exclusions. Rather, *Henglein* merely held that, in determining whether a plan *exists*, courts should determine whether a reasonable person could ascertain the elements of a plan. *Id.* at 401. It is only in this context that the Third Circuit refers to ERISA's purpose of protecting a plan participant's reasonable expectations. *Id.*

review of the circuit court decisions referencing reasonable expectations (including the cases cited by Petitioner) does not reveal any split of authority between the Tenth Circuit and Fifth Circuit, on the one hand, and the other circuits referenced by Petitioner, on the other hand.[5]

The Ninth Circuit first applied the "reasonable expectations" doctrine to an ERISA-governed insurance contract in the case of *Saltarelli v. The Bob Baker Group Medical Trust*, 35 F.3d 381, 387 (9th Cir. 1994).[6] *Saltarelli* concluded that a pre-existing condition exclusion that was found in the middle of the plan's Definitions section (as opposed to the "Exclusions and Limitations" section) and that could only be understood based on a coordinated reading of three separate definitions "was not clear, plain and conspicuous enough to negate layman Saltarelli's objectively reasonable expectations of coverage." *Id.* at 387. Significantly, *Saltarelli* did not specify whether the plan at issue afforded discretion to the administrator or whether the district court had applied an abuse of discretion or *de novo* review to the determination. In addition, *Saltarelli* made clear that it was not holding that the reasonable expectations doctrine would apply in every ERISA case. To the contrary, the Ninth Circuit specifically stated: "We leave comprehensive delineation of the doctrine's scope to future cases." *Id.* at 387, n. 8. Subsequent Ninth Circuit decisions

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[5] Other than the Ninth Circuit, the circuit courts that have referenced the "reasonable expectations" doctrine in the ERISA context have done so briefly with either no or limited analysis of the doctrine's scope. In addition, most circuit courts have only applied the doctrine in cases in which the ERISA plans at issue do not afford plan administrators with discretion to interpret the plan.

[6] Prior to *Saltarelli*, circuit courts had only "obliquely" addressed the issue. *Saltarelli*, 35 F.3d at 386, n.5.

confirm the narrow application of the doctrine. *See, e.g.*, *Estate of Shockley v. Alyeska Pipeline Svc. Co.*, 130 F.3d 403, 407 (9th Cir. 1997) ("extending the doctrine to ERISA pension plans would be inconsistent with circuit and Supreme Court precedent requiring abuse of discretion review of a retirement committee's actions"); *Winters*, 49 F.3d at 554-55 (reasonable expectations doctrine does not apply as part of a consideration of whether an employer/administrator abused its discretion in interpreting a plan exclusion); *Winterstein v. Stryker Corp. Group Life Ins. Plan*, 157 F. App'x 20 (9th Cir. 2005) ("To the extent ambiguity is found in the plan's provision . . ., upon *de novo* review we must construe that ambiguity in favor of [the plaintiff]. Both the doctrine of *contra proferentem* and the doctrine of reasonable expectations require that.").

The other circuit courts that have mentioned the reasonable expectations doctrine have generally referenced it in the context of cases involving *de novo* review, or have found no need to analyze it because it clearly did not apply. For example, in *Gallagher v. Reliance Standard Life Insurance Co.*, the Fourth Circuit held: "If a plan does not clearly grant discretion, the standard of review is de novo. . . . Any ambiguity in an ERISA plan 'is construed against the drafter of the plan, and it is construed in accordance with the reasonable expectations of the insured.'" 305 F.3d 264, 269 (4th Cir. 2002) (quoting *Bynum v. CIGNA Healthcare of N.C., Inc.*, 287 F.3d 305, 313-14 (4th Cir. 2002)) (internal citation omitted). *See also Wheeler*, 62 F.3d at 638 (considering the insured's reasonable expectations only after determining that the plan did not give the administrator discretion to interpret it).

The Second Circuit has likewise not engaged in any detailed analysis of the application of the reasonable expectations doctrine in the ERISA context. In *Lifson v. INA*

Life Insurance Co., the Second Circuit merely mentions that plan terms "must be construed in accordance with the reasonable expectations of the insured." 333 F.3d 349, 353 (2d Cir. 2003)(citations omitted). In *Lifson*, the defendants were not provided discretion under the plan and, therefore, the plan administrator's decision was reviewed *de novo*. *Id.* at 352. Thus, the Second Circuit has not applied the doctrine to cases in which the administrator has discretionary review under the plan and *Lifson*'s brief mention of the doctrine provides no indication that the Second Circuit would do so.

Similarly, in *Ruttenberg v. United States Life Insurance Co.*, the Seventh Circuit only referenced consideration of a beneficiary's reasonable expectations in a footnote. 413 F.3d 652, 668, n. 19 (7th Cir. 2005). Importantly, however, *Ruttenberg* involved a *de novo* review that afforded "no deference to U.S. Life's interpretation of contract terms." *Id.* at 660. Based on the Seventh Circuit's limited reference to the doctrine in the context of a case involving *de novo* review, there is no indication that the Seventh Circuit would find that the doctrine applied in an abuse of discretion setting.[7]

In attempting to demonstrate that a conflict exists among the circuits, Petitioner asserts that the Fifth Circuit (in this case) and the Tenth Circuit have rejected the reasonable expectations doctrine. As noted previously, however, the Fifth Circuit did not reject the reasonable expectations

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[7] In a footnote in *Carr v. Reliance Standard Life Insurance Co.*, the Sixth Circuit references a plaintiff's argument that his reasonable expectations concerning a plan's interpretation should apply. 363 F.3d 604, 607 n.3 (6th Cir. 2004). Without analyzing the argument, the court equated the argument to a *contra proferentum* rule that only applies to ambiguous terms and, for support, cited an earlier Sixth Circuit case that addressed *contra proferentum* but did not address reasonable expectations. *Id.* (citing *Marquette Gen. Hosp.*, 315 F.3d at 632 n.1).

doctrine in this case. Similarly, the Tenth Circuit decision to which Petitioner points does not expose any conflict. *Kimber v. Thiokol Corp.*, 196 F.3d 1092 (10th Cir. 1999). To the contrary, the Tenth Circuit relied on the Ninth Circuit's *Estate of Shockley* decision in concluding that the doctrine did not apply in that case. *Id.* at 1101. Specifically, the Tenth Circuit held that, in a case in which the administrator was afforded discretion to interpret the terms of an ERISA plan, "[a]llowing a beneficiary's expectations under the plan to dominate an administrator's interpretation would obliterate the discretionary review required by *Firestone*." *Id.* (citing *Estate of Shockley*, 130 F.3d 403, 407 (9th Cir. 1997)). Thus, the Tenth Circuit held that "the reasonable expectation doctrine is inapplicable to the review of an ERISA disability benefits plan under the arbitrary and capricious standard." *Id.* In sum, there is no circuit court split on the application of the doctrine of reasonable expectations.

III. GPA AND CIGNA CANNOT BE LIABLE FOR PAYMENT OF BENEFITS UNDER THE PLAN.

Finally, GPA and CIGNA can have no liability to Petitioner on her claim for recovery of benefits under the Plan. Petitioner appears to believe that GPA and CIGNA are insurers that have somehow provided insurance benefits under the Plan. The SPD explicitly states the Plan is self-insured by CROSSMARK, and GPA and CIGNA provide claims administration services to the Plan. Resp. App. 3b, 4b, 8b, 9b.

CROSSMARK was and is the only Plan administrator of the Plan, which is self-funded by CROSSMARK. GPA and CIGNA were not the Plan administrator, nor were they the Plan's insurer. Resp. App. 3b, 4b, 8b, 9b. GPA and CIGNA were merely third-party claims administrators with which CROSSMARK contracted to assist it in administering benefits

to employees. All payments made under the Plan were made from CROSSMARK funds, not GPA's or CIGNA's.

The Second Circuit has encountered this very situation, in a case filed against CIGNA under ERISA. *Lee v. Burkhart*, 991 F.2d 1004, 1006 (2d Cir. 1993). In *Lee*, the employer that provided a self-funded benefits plan filed for bankruptcy, leaving claims unpaid. *Id.* The participants then sued CIGNA, which they believed to be the insurer of the plan. *Id.* The court held that CIGNA had no liability under ERISA for benefits or for failure to provide information because only the plan and its administrator could be liable for such claims under the plan's terms. *Id.* at 1009-10. *See also Everhart v. Allmerica Fin. Life Ins. Co.*, 275 F.3d 751, 754 (9th Cir. 2001), *cert. denied*, 536 U.S. 826 (2002) (holding claims for benefits can be only against plan); *Layes v. Mead Corp.*, 132 F.3d 1246, 1249 (8th Cir. 1998) (permitting suit against plan administrator but not employer); *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997) (holding that outside insurance company that serviced plan was not proper defendant because it was not plan administrator); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1490 (7th Cir. 1996) ("ERISA permits suits to recover benefits only against the Plan as an entity. . .") (citation omitted); *Daniel v. Eaton Corp.*, 839 F.2d 263, 266 (6th Cir.), *cert. denied*, 488 U.S. 826 (1988) (holding that only proper party in suit for benefits under ERISA plan is party in control of plan administration).

As a result, GPA and CIGNA cannot be liable to Petitioner for benefits under the Plan.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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APPENDIX

MURRAY EXHIBIT 8

[p.1]

CROSSMARK, Inc.
Benefits with Choice Plan — PPA
Excerpt

[p.2]

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GENERAL LIMITATIONS
MEDICAL AND VISION CARE BENEFITS

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;

- for or in connection with a Sickness which is covered under any worker's compensation or similar law;

* * *

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SUMMARY PLAN DESCRIPTION

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Type

The Plan is a health care benefit plan.

Type of Administration

The Administrator of the Plan shall have the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. Various aspects of the Plan are administered by CG and subsidiaries of CIGNA

Healthplan, Inc. Service of legal process may also be made upon a Plan Trustee (if any).

* * *

[p.78]

SUMMARY PLAN DESCRIPTION

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this plan are self-insured by the Employer.

This document is issued by:

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

MURRAY EXHIBIT 5

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR CROSSMARK, INC. EXCERPT

PURPOSE

It is the intention of the Plan Administrator, CROSSMARK, Inc., to hereby establish a program of benefits constituting a self-funded "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

IN WITNESS WHEREOF, the Plan Administrator has executed, and the Claims Administrator has acknowledged, this Plan Document as of the Plan effective date shown herein.

The effective date of the Plan is January 1, 1997. Restated January 1, 1999.

* * *

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[p.3]

GENERAL INFORMATION

This Plan Document describes the benefits for the Employees of CROSSMARK, Inc. and its subsidiaries and affiliates.

This statement is required by the Employee Retirement Income Security Act of 1974 (ERISA) and provides important information regarding your rights under this law.

Group to Which This Statement Applies
CROSSMARK, Inc.
6400 International Parkway
Plano, Texas 75093

Plan Administrator/Plan Sponsor
CROSSMARK, INC.
6400 International Parkway
Plano, Texas 75093
972-349-1322

Type of Plan
Self-Funded Welfare
Benefit Plan

Agent for Service of Legal Process
Rodger L. Fisher, Vice President
CROSSMARK, Inc.
6400 International Parkway
Plano, Texas 75093
972-349-1322

Claims Administrator
Group & Pension Administrators, Inc.
300 Municipal Drive
Richardson, Texas 75080
972-238-7900

Regional Office of Pension and Welfare Benefit Administration
Pension and Welfare Benefits Administration (PWBA), Department of Labor
Dallas Regional Office
525 Griffin Street, Rm 707
Dallas, Texas 75202-5025
214-767-6831

Plan Year
January 1 through December 31 of the same year

Employer Tax ID Number
75-2670784

IRS Plan ID Number
501

* * *

[p.5]

INTRODUCTION

CROSSMARK, Inc., hereinafter referred to as "Employer", hereby establishes a self-funded Employee Welfare Benefit Plan hereinafter referred to as the "Plan"; the rights and privileges of which shall pertain to Employees and their Dependents with respect to such Plan. The benefits are to be provided under the Plan through funds contributed by the Employer and Employees.

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of Covered Medical Expenses and Covered Dental Expenses.

EFFECTIVE DATE

The effective date of the Plan is January 1, 1997 as of 12:01 a.m. Restated January 1, 1999.

* * *

NAMED FIDUCIARY

The named Fiduciary is CROSSMARK, Inc., who shall have the authority to control and manage the operation and administration of the Plan. The Employer may delegate responsibilities for the operation and administration of the Plan. The Employer or Board of Directors of the Employer shall have the authority to amend the Plan, to determine its policies, to appoint and remove service providers, adjust their

compensation (if any), and exercise general administrative authority over them. The Employer has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

* * *

[p.27]

MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons:

GENERAL EXCLUSIONS AND LIMITATIONS

* * *

3. Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law.

* * *

MURRAY EXHIBIT 1

GROUP & PENSION ADMINISTRATORS, INC.
300 Municipal Drive Richardson, TX 75080
(972)238-7900 Fax (972)669-8155

May 11, 2001

NEVA J. MURRAY
8910 GOLDEN BROOK
SAN ANTONIO TX 78250

EMPLOYER ID: M870033
CERTIFICATE: 0251

RE: HUGH MURRAY
EMPLOYEE: NEVA MURRAY

We have received a claim for the above-referenced person and are in the process of evaluating for payment. In order to correctly process this claim, we need the following information from your records:

The claim indicates the services were provided for treatment of an injury or accident on 2-12-01. Please provide a complete description of exactly how, where and when this injury or accident took place:

Fell from Attic through ceiling to concrete floor over garage,
Where: 8570 Dawnwood, San Antonio, Tx 78750
When: 2-12-01 in the afternoon

Also, please fill out the following:

Was the accident related in any way to your work?

Yes

If yes, please explain:

Was on job. Self employed - Admiral Pest Control, 7126 Eckhert Rd. Ste 211, San Antonio, 78238, (210) 647-1508

Was the accident the result of a third party?

Not Sure

Name and address of third party insurance company:

We do not have other Ins.

If a police report was made, please include a copy of the name and address of the Police Department:

I don't think so.

Your attention to this request is important since all charges are pending the receipt of this information. Thank you for your assistance. If you have any questions, please contact our Customer Service Department. We sincerely appreciate your cooperation in this matter.

* * *

_____I will be pursuing a claim against the third party(s) who caused, contributed to, or aggravated said injury or accident. The name, address, and phone number o the attorney who will represent me is attached.

_____I will not be pursuing a claim against the third party(s).

XXX I am not sure at this time.

I hereby warrant that I have take no action to defeat said Plan's subrogation rights.

Signed /s/ Neva Murray Date 5-29-01
HUGH MURRAY, or Participating Employee if dependent child.

Subscribed and sworn before me on this 29 day of May, 2001.

/s/ Judith F. Cline
NOTARY PUBLIC

I, Neva Murray, wife of Hugh Murray is signing this due to my husband Hugh Murray is not able to sign at this time.

MURRAY EXHIBIT 18

Johnnie Kay Monk
Claim Service Consultant

CIGNA
Routing 244
600 East Taylor
Sherman TX 75414
Telephone 903.870.2724
Facsimile 903.893.7059
johnnie.monk@cigna.com

August 13, 2001

NEVA MURRAY
8910 GOLDEN BROOK
SAN ANTONIO, TX 78250

RE: Hugh Murray
Group # 25192
Employer: Crossmark

Dear Ms. Murray:

We regret to inform you that CIGNA HealthCare cannot process claims going forward on your spouse's file relating to the injury incurred on 2/1/01. CIGNA should not have covered these charges due to the following exclusion listed under the General Limitations in your Summary Plan Description:

No payment will be made when charges are received for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.

If you'd like to discuss this matter further, you may do so by contacting CIGNA HealthCare. We value your business and truly want to be of service. With your insurance certificate number (listed above) ready as a reference, please call me toll free at 1.800.525.5803 ext. 2724, any business day.

Sincerely,

/s/ Johnnie Kay Monk
Johnnie Kay Monk

MURRAY EXHIBIT 36

Debra Shires
Proclaim Correspondence
Sherman Customer Service

CIGNA
Routing 244
P.O. Box 188013
Sherman TX 75090
Telephone 1.903.870.2691
Facsimile 1.903.868.9599
shires@cigna.com

November 5, 2001

NEVA S MURRAY
8910 GOLDEN BROOK
SAN ANTONIO, TX 78250

Dear:

Connecticut General Life Insurance Company, on behalf of your Employer Plan Denial of Level One Medical Necessity Appeal
Insured ID #: 454-11-3500

Dear Mrs. Murray:

After reviewing your request and all supporting documentation, I have decided to uphold the original decision to deny your claims as occupationally related. This decision was based on the following:

This was a result of an injury or illness where wages were being received. This is exclusion under your plan.

I regret that this response is not more favorable. If you are not satisfied with this decision, you may request a second level appeal review by the Appeals Committee. This Committee will include physician(s) who where not involved in any previous review of your issue. If you decide to continue with a second level appeal review, please promptly send your request and any additional supporting documentation, which you think the Committee, should review to:

Designated Appeal Unit
Attn: Appeals Coordinator
P.O. Box 188015
Chattanooga, TN 37422-8015

Sincerely,

/s/ Debra Shires
Debra Shires

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

CIVIL ACTION NO. SA-03-CA-0085

NEVA MURRAY	)
Plaintiff,	)
	)
VS.	)
	)
CROSSMARK SALES, INC.,	)
CONNECTICUT GENERAL LIFE	)
INSURANCE COMPANY, A/K/A	)
CIGNA HEALTHCARE; AND	)
GROUP & PENSION	)
ADMINISTRATORS, INC.,	)
Defendants.	)
	)

ORAL AND VIDEOTAPED DEPOSITION OF
NEVA MURRAY
November 7, 2003
Excerpt

* * *

[p.15]

* * *

Q. Well, let me rephrase that and see if I can -- because I want to know what your claims are. Are your claims -- you're claiming that the defendants wrongfully denied benefits

to you under the CROSSMARK health plan based on medical expenses related to Mr. Murray's injury on February 12th of 2001?

A. Yes. The denial of the insurance, yes.

Q. Okay. The denial of benefits to pay for expenses that have arisen from Mr. Murray's February 12th, 2001 injury?

A. Yes.

Q. Okay. I'd like to talk a little bit about Mr. Murray's injury. And I'm going to refer to your husband as Mr. Murray, if that's okay.

A. Okay.

Q. Mr. Murray's February 12th, 2001 injury [p.16] occurred while he was performing his job; correct?

A. While he was working, yes.

Q. Okay. And could you describe the details of how -- or explain how, to your knowledge, Mr. Murray was injured on that day?

A. He was working in the attic of a house and he fell through the ceiling over the garage onto the garage floor, concrete floor.

Q. And the reason he was at this house was because he was performing pest control services for the tenant of that house?

A. Yes.

Q. Okay. And do you recall the location or the tenant?

A. No. I don't remember at this time, no.

Q. Okay. And Mr. Murray was at that location to perform pest control services for which he would have received payment?

A. Yes.

* * *

[p.88]

* * *

Q. Okay. What's the date of Exhibit 18?

A. August 13th, 2001.

Q. Okay. And CIGNA stated that it regretted to inform you that CIGNA HealthCare cannot process claims going forward on your spouse's file relating to the injury incurred on February 1, 2001?

A. Yes.

Q. CIGNA should not have covered these charges due to the following exclusion listed under the general limitations in your summary plan description. And then it sets forth the exclusion as no payment will be made when charges are received for or in connection with an injury arising out of or in the course of any employment for wage or profit. Do you see that?

A. Uh-huh.

Q. Okay. And when you received Exhibit 13, you understood that CIGNA was denying your claims under the CROSSMARK medical plan from that point forward?

A. Right. That was the beginning of me knowing [p.89] all about this. That's the beginning of me knowing about the exclusions.

Q. When you received this letter?

A. Uh-huh.

Q. Yes?

A. Yes.

Q. Okay. And you understood from Exhibit 18 that the reason CIGNA was denying your claims for benefits under the CROSSMARK medical plan was because of the general limitation in the plan set forth in this letter?

A. I understood what the letter said.

Q. Okay. The exclusion being no payment will be made when charges are received for or in connection with an injury arising out of or in the course of any employment for wage or profit; correct? You understood that --

A. I understood at that time. I didn't know about this until August.

Q. Okay. All I'm asking is when you received this letter, you understood it?

A. Yes. I understood what it said.

Q. Okay. And you understood that that was the reason CIGNA was denying your claims for benefits related to Mr. Murray's injury?

A. Yes. I understood that's what the reason was.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

CIVIL ACTION NO. SA-03-CA-0085

NEVA MURRAY, INDIVIDUALLY AND AS GUARDIAN OF HUGH MURRAY, WARD, Plaintiffs,	)
V.	)
CROSSMARK SALES, INC.; CONNECTICUT GENERAL LIFE INSURANCE COMPANY, A/K/A CIGNA HEALTHCARE; AND GROUP & PENSION ADMINISTRATORS, INC., Defendants.	)

ORAL DEPOSITION OF
CHERYL GRAHAM
November 20, 2003
Excerpt

The ORAL DEPOSITION OF CHERYL GRAHAM, was taken by Plaintiffs before April C. Presley, a Certified Shorthand Reporter, in and for the State of Texas, at the offices of Crossmark Sales, Inc. 5100 Legacy Drive, City of Plano, County of Collin, State of Texas, between the hours of 9:13 a.m and 2:36 p.m. on the 20th day of November 2003, pursuant to the Federal Rules of Civil Procedure and the agreements hereinafter set forth.

* * *

[p.44]

* * *

A. The schedule of benefits changed, not the plan document. But the schedule of benefits changed from February 12th, 2001, to March 1st, 2001.

Q. Were those changes in writing, or did somebody set those changes down in writing?

A. Yes.

Q. Where would that be? Would that be -- what document would that be in, the changes?

A. The changes? It's in the enrollment guide. And there were other communication pieces in the open enrollment packet that also talked about the changes.

* * *

[p.52]

* * *

Q. Is that a true, complete, and correct copy of the Plan Document and Summary Plan Description for Crossmark that became effective March 1, 2001?

A. Yes, it looks like it is.

* * *

[p.53]

* * *

Q. When did the Plan Document and Summary Plan Description marked as Deposition Exhibit 1 cease to apply to the claim submitted by Mrs. Murray on behalf of her husband?

A. The schedule of benefits changed on March 1st, but the actual plan language stayed in place until this one was published, which was late June or July of 2001.

* * *